THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

IN RE Phenylpropanolamine (PPA) Products Liability Litigation --- This document relates to all actions.	No. MDL 1407 CASE MANAGEMENT ORDER NO. 6 (CASE SPECIFIC FACT DISCOVERY PROCEDURES AND PLAN)

cc: counsel; BJR

I. INTRODUCTION.

The parties having submitted a proposed Case Management Order No. 6, setting forth the proposed schedule and protocol for conducting all case-specific fact discovery within MDL 1407 for all cases transferred to this Court, and after review and consideration of the parties' submission, the Court hereby orders as follows:[1]

II. SOLE AND EXCLUSIVE FORUM FOR CONDUCTING CASE-SPECIFIC FACT DISCOVERY.

All case-specific fact discovery in cases transferred to this Court for purposes of the coordination of discovery and other common pretrial proceedings shall occur under the express limitations set forth below and during the time period permitted herein. Upon remand to transferor courts, there shall be no case-specific fact discovery conducted by any party, except upon a showing of good cause to the transferor judge.

[1] This order does not apply to the economic injury class actions.

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III. CASE-SPECIFIC FACT DISCOVERY CONDUCTED BY DEFENDANTS.

Case-specific fact discovery by defendants shall be governed by applicable Federal Rules of Civil Procedure and Local Rules except as otherwise provided herein or in any subsequent Case Management Order.

The following protocol and limitations shall apply in all cases transferred to this Court:

A. Fact Sheet. Plaintiff(s) in each case transferred to this Court shall complete a **Plaintiff's Fact Sheet** ("Fact Sheet"), a copy of which is attached hereto at Tab A. Within five (5) business days after the entry of this CMO No. 6, Liaison Counsel for Plaintiffs shall forward (electronically or otherwise) to each plaintiff's counsel a copy of this CMO No. 6 and Fact Sheet, and certify that fact to Liaison Counsel for Defendants. Plaintiffs in all cases currently docketed in this Court as of the date of entry of this CMO No. 6, shall complete the Fact Sheet and serve same upon Defendants' Liaison Counsel and counsel of record in the applicable case no later than 45 days after transmission of the Fact Sheet. Plaintiffs in all cases transferred and docketed to this Court after the date of entry of this CMO No. 6, shall be served with a copy of this CMO No. 6 and Fact Sheet by Defendants' Liaison Counsel upon the docketing of this case in the MDL in the Western District of Washington, and shall complete the Fact Sheet and serve same upon Defendants' Liaison Counsel and counsel of record in the applicable case no later than 45 days after service of the Fact Sheet.

Should any plaintiff fail to serve a Fact Sheet within the time allowed, Defendants' Liaison Counsel shall send a warning letter to that plaintiff's attorney of record, with a copy to the Plaintiffs' Liaison Counsel. Should a plaintiff fail to provide complete responses within 30 days of the sending of the warning letter, defendants may move the Court for appropriate relief. The parties shall meet and confer as soon as practicable to resolve disputes concerning answers to Fact Sheets. Motions to compel should only be filed on those issues that cannot in good faith be resolved.

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B. Interrogatories. At any time during the period allowed for case-specific fact discovery, defendants may propound no more than ten (10) interrogatories, including discrete subparts pursuant to Fed. R. Civ. P. 33, directly to the counsel of record for plaintiff(s) in each respective case. These interrogatories may not duplicate any request contained in the *Plaintiff's Fact Sheet*. Answers to interrogatories shall be served by plaintiffs directly to counsel of record for each defendant, no later than forty-five (45) days after receipt of same.

The parties shall meet and confer as soon as practicable to resolve disputes concerning the responses to any interrogatories. Motions to compel should only be filed on those issues that cannot in good faith be resolved.

C. Rule 34 Document Requests. At any time during the period allowed for case-specific fact discovery, each defendant may serve no more than ten (10) case-specific Rule 34 document requests directly to plaintiff(s) of each case. Defendants may not duplicate any request for documents contained in the *Plaintiff's Fact Sheet*. Absent agreement by the plaintiff, defendants may apply to the Court to serve additional document requests only upon a showing of good cause and the specific identification of the additional request(s) sought to be served. Responses to any such Rule 34 request shall be served directly to counsel of record for defendants in the individual case filed by the responding plaintiff, no later than forty-five (45) days after receipt of same.

The parties shall meet and confer as soon as practicable to resolve disputes concerning withheld documents. Motions to compel should only be filed on those issues that cannot in good faith be resolved.

D. Depositions. Defendants shall be entitled to conduct a total of ten (10) depositions as part of their case-specific fact discovery in each case transferred to this Court. For purposes of this order, treating physicians shall be considered "fact" witnesses. Absent agreement by the plaintiff, defendants may apply to the Court to conduct further depositions only upon a showing of good cause and the specific identification of the

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individuals(s) sought to be deposed. The deposition of each plaintiff shall be limited to seven (7) hours of actual deposition time, absent agreement or further order of this Court upon a showing a good cause. Depositions of all other case-specific fact witnesses shall be limited to four (4) hours of actual deposition time, unless defendants can show a need for additional time to conduct a particular non-party deposition.

Case-specific fact depositions in any particular case may commence no earlier than one hundred and twenty (120) days after the plaintiff serves a completed Fact Sheet on defendants, except as provided in paragraph IV.C of this CMO No. 6, otherwise agreed to by the parties, or upon further order of this court. Defendants may not depose any case-specific witness, including plaintiffs, more than once, without a showing of good cause and necessity. Counsel shall attempt in good faith to cooperate in the scheduling of depositions permitted in this section considering the demands on the time and schedules of both the parties and their respective counsel. Counsel shall meet and confer as soon as practicable to resolve any scheduling dispute(s). Motions to compel or for protective orders shall only be filed on those issues that cannot in good faith be resolved. In all other respects, depositions conducted by defendants pursuant to this order shall comply with the applicable deposition procedures and protocols established in CMO No. 1.

IV. CASE-SPECIFIC FACT DISCOVERY CONDUCTED BY PLAINTIFFS.

Plaintiffs shall be permitted to conduct limited case-specific fact discovery as to defendants as set forth below, which shall be governed by applicable Federal Rules of Civil Procedure and Local Rules except as otherwise provided herein or in any subsequent Case Management Order.

The following protocol and limitations apply in all cases transferred to this Court:

A. Interrogatories. At any time during the period allowed for case-specific fact discovery, each plaintiff may propound no more than ten (10) case-specific interrogatories, including discrete subparts pursuant to Fed. R. Civ. P. 33, directly to the counsel of record

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for defendant(s) in each respective case. By case-specific, the Court means interrogatories addressing issues specific to the case such as product identification, product lot number, product distribution information as to the plaintiff's pharmacy or retail store at issue and other similar matters. Individual plaintiffs may not duplicate any interrogatory contained in the *Master First Set of Interrogatories Propounded to Each Defendant* referenced in CMO No. 1. Answers to case-specific interrogatories shall be served by defendants directly to counsel of record for each plaintiff, no later than forty-five (45) days after receipt of same.

The parties shall meet and confer as soon as practicable to resolve disputes concerning withheld documents. Motions to compel should only be filed on those issues that cannot in good faith be resolved.

B. Rule 34 Document Requests. At any time during the period allowed for case-specific fact discovery, each plaintiff may serve no more than ten (10) case-specific Rule 34 document requests directly to the defendant(s) of record in the respective case. By case-specific, the Court means interrogatories addressing issues specific to the case such as product identification, product lot number, product distribution information as to the plaintiff's pharmacy or retail store at issue and other similar matters. Individual plaintiffs may not duplicate any request contained in the *Master First Request for Production of Documents to Each Defendant* referenced in CMO No. 1. Absent agreement by the defendant(s), plaintiffs may apply to the Court to serve additional document requests only upon a showing of good cause and the specific identification of the additional request(s) sought to be served. Rule 34 responses shall be served directly to counsel of record for each plaintiff, no later than forty-five (45) days after receipt of same.

The parties shall meet and confer as soon as practicable to resolve disputes concerning withheld documents. Motions to compel should only be filed on those issues that cannot in good faith be resolved.

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C. Case-Specific Depositions Conducted by Plaintiffs. Except as provided below, case-specific fact depositions in any particular case may commence no earlier than one hundred and twenty (120) days after the plaintiff serves a completed Fact Sheet on defendants, unless otherwise agreed to by the parties or upon further order of this court. Counsel shall attempt in good faith to cooperate in the scheduling of depositions permitted in this section considering the demands on the time and schedules of both the parties and their respective counsel. Counsel shall meet and confer as soon as practicable to resolve any scheduling dispute(s). Motions to compel or for protective orders shall only be filed on those issues that cannot in good faith be resolved. If there is an imminent risk that the plaintiff may become incapacitated or perish at any time prior to the expiration of the 120 day period discussed above, plaintiff's counsel may take a preservation deposition of the plaintiff after providing reasonable notice pursuant to the terms of CMO No. 1 given the circumstances of the plaintiff's health. Defendants are entitled to take a discovery deposition of the plaintiff prior to the taking of a preservation deposition. Any time used by Plaintiffs in conducting a deposition pursuant to the terms of this section shall not reduce the Defendants' permitted time to conduct that deposition as set forth in paragraph III.D. herein. In all other respects, depositions conducted by plaintiffs pursuant to this order shall comply with the applicable deposition procedures and protocols established in CMO No. 1.

V. DOCUMENT SUBPOENAS TO NON-PARTIES.

Commencing upon entry of this Order, any party may serve case-specific subpoenas on non-parties for the production of documents without testimony pursuant to Fed. R. Civ. P. 45.

VI. COMPLETION DEADLINE FOR ALL CASE-SPECIFIC FACT DISCOVERY AND REMAND.

Except as to cases where an extension of time has been permitted under Section III above: (a) case-specific discovery for cases transferred and docketed in this Court as of

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February 12, 2002 shall be completed no later than February 28, 2003; and (b) case-specific discovery for cases transferred and docketed in this Court after February 28, 2002 shall be completed no later than twelve (12) months after the date of docketing in this Court. Absent mutual consent of the parties thereto or further order of the court, no case shall be subject to remand to its transferor court prior to the completion deadline for case-specific fact discovery applicable to it.

DATED this 18th day of March, 2002.

The Honorable Barbara Jacobs Rothstein
United States District Court Judge

Presented by:

LANE POWELL SPEARS LUBERSKY LLP

By D. Joseph Hurson
D. Joseph Hurson
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Co-Liaison Counsel for the PPA Manufacturer-Defendants

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

IN RE Phenylpropanolamine (PPA) Products Liability Litigation	:	MDL No. 1407

PLAINTIFF'S FACT SHEET

Please provide the following information for each individual on whose behalf a claim is being made. In filling out this form, please use the following definitions: (1) "health care provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric, mental, emotional or psychological care or advice, and any pharmacy, weight loss center, counselor, dentist, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, therapist, nurse, herbalist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you; (2) "document" means any writing or record of every type that is in your possession or the possession of your counsel, including but not limited to written documents, e-mails, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phono-records, nonidentical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form. You may attach as many sheets of paper as necessary to fully answer these questions. If you have any documents (as defined above), including, but not limited to, packaging, instructions, PPA-containing product or other materials or items that you are requested to produce as part of answering this fact sheet or that relate to PPA, any PPA-containing product or medication you allegedly took, or the incident, injuries, claims or damages that are the subject of your complaint, you must NOT dispose of, alter or modify these documents or materials in any way. You are also required to give all of these documents and materials to your attorney as soon as possible. If you are unclear about these obligations please contact your attorney.

I. CASE INFORMATION

A. Please state the following for the civil action which you filed:

1. Case Caption:_____

2. Civil Action No. in Western District of Washington:_____

3. Transferor Court and Civil Action No. in that court _____

4. Please state name, address, telephone number, fax number and e-mail address of principal attorney representing you.

_____
Attorney Name

_____
Firm

_____
Street Address

_____
City, State and Zip Code

_____
Telephone number Fax Number

_____
e-mail address

B. If you are completing this questionnaire in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

1. _____
Your Name

2. _____
Street Address

3. _____
City, State and Zip Code

4. In what capacity are you representing the individual

_____

5. If you were appointed by a court, state the:

_____ _____
Court Date of Appointment

6. Your relationship to deceased or represented person:

_____

7. If you represent a decedent's estate, state the date of death of the decedent.

_____

[If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person who used PPA-containing medications or products. Those questions using the term "You" refer to the person who used the PPA-containing medications or products. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.]

C. Claim Information

Do you claim that any physical, psychiatric, psychological or emotional injuries, illnesses and/or conditions have resulted from your use of PPA-containing medications and/or products?

Yes_____ No_____

If the answer to the foregoing question is yes, state the nature of the injuries, illnesses or conditions.

_____

_____

_____

D. Identify by complete brand name and/or trade name the PPA-containing medications and/or products you claim caused your injuries, including the specific type or version of the medication or product, and the date on which you ingested each such product or medication.

_____

_____

_____

II. PERSONAL INFORMATION

A. Last Name:_____

First Name:_____

Middle Name or Initial:_____

B. Maiden or other names used or by which you have been known, and the dates during which you were known by such names:

_____

C. Present Street Address:_____

_____

D. Current or last employer

_____

Name

_____

Street Address, City, State and Zip Code

_____

Dates of Employment

_____

Occupation

E. Social Security Number:_____

F. Driver's License Number:_____

G. Date and Place of Birth:_____

H. Sex: Male_____ Female_____

I. Racial and Ethnic Background:_____

J. Have you ever served in any branch of the military?

Yes_____ No_____

1. Branch and dates of service:

_____

2. Were you discharged for any reason relating to your medical, physical, psychiatric or emotional condition?

Yes_____ No_____

If yes, state what that condition was.

_____

3. Have you ever served overseas?

Yes_____ No_____

If yes, state location and dates.

_____

K. Have you ever been rejected from military service for any reason relating to your health or physical condition?

Yes_____ No_____

L. Have you ever filed a worker's compensation claim?

Yes_____ No_____

If yes, please state:

1. Year claim was filed:_____

2. Where claim was filed:_____

3. Claim/docket number, if applicable_____

4. Nature of disability:_____

5. Period of disability:_____

[Attach additional sheets as necessary to describe more than one claim.]

M. Have you ever filed a social security disability claim?

Yes_____ No_____

If yes, please state:

1. Year claim was filed:_____

2. Where claim was filed:_____

3. Nature of disability:_____

4. Period of disability:_____

[Attach additional sheets as necessary to describe more than one claim.]

N. Have you ever filed any other form of disability claim?

Yes_____ No_____

If yes, please state:

1. Year claim was filed:_____

2. Where claim was filed:_____

3. Name of insurer/employer or other party to whom claim was made:_____

4. Nature of disability:_____

5. Period of disability:_____

O. Have you ever been denied life insurance for reasons relating to your medical, physical, psychiatric or emotional condition?

Yes_____ No_____

If yes, please state when, the name of the company and the company's stated reason for denial.

_____

_____

P. Have you ever filed a lawsuit or made a claim, other than in the present suit, seeking damages?

Yes_____ No_____

If yes, state the court in which such claim was filed, the caption, case name and/or names of adverse parties, and the civil action or docket number assigned to each such claim, action or suit, and a brief description of the claims asserted.

_____

_____

Q. Have you been convicted of a felony within the last 10 years?

Yes_____ No_____

R. Identify each address at which you have resided during the last ten (10) years, including time periods of residence

_____

S. Has any insurance or other company provided medical coverage to you (either directly or through a group including any employer of yours) or paid medical bills on your behalf at any time, beginning ten (10) years before your alleged PPA injury through the present?

Yes ____No_____

If "yes," then as to each such Company, separately state:

(i) Name of company;
(ii) Address of company;
(iii) The account/policy number or designation;
(iv) Dates of coverage; and
(v) When claim was made.

T. Have you ever been out of work for more than thirty (30) days for reasons related to your health?

Yes_____ No_____

If yes, please state the dates, employer and health condition:

III. EDUCATIONAL HISTORY

Identify each school, college, university or other educational institution you have attended, the dates of attendance, courses of study pursued and diplomas or degrees awarded:

IV. FAMILY INFORMATION

A. Have you ever been married?

Yes_____ No_____

B. If yes, for each spouse/former spouse state:

1. Spouse's name:_____

2. Dates of marriage:_____

3. Spouse's date of birth:_____

4. Spouse's occupation:_____

5. Spouse's address:_____

6. Nature of termination of marriage:_____

7. Date of dissolution of marriage:_____

C. Has your spouse filed a loss of consortium claim?

Yes_____ No_____

D. Please provide the following information for your grandparents, parents, siblings and children:

Name	Relationship	Date of Birth	Date Of Death (if applicable)	Occupation

V. CURRENT MEDICAL CONDITION

A. Do you currently suffer from any physical injuries, illnesses or disabilities?

Yes_____ No_____

1. Identify the injury, illness, or disability, symptoms and date(s) of onset:

_____

Injury, illness or disability

_____

Symptoms

_____

Date(s) of onset

_____

Date(s) of diagnoses

2. By whom first diagnosed:

_____ _____

Physician's Name Specialty

_____

Address (if not otherwise provided)

VI. MEDICAL BACKGROUND

A. Height:_____

B. Current Weight:_____

C. Lowest and highest weight since age 18:_____

D. To the best of your knowledge, have you used any of the following medications or substances from 10 years prior to the date of your injury through the present?

	Date First Taken	Date Last Taken

1. Oral contraceptives

   Yes No

2. Monamine Oxidase ("MAO") inhibitors

   Yes___ No___

3. Anticoagulants

   Yes___ No___

4. Antidepressants

   Yes___ No___

5. Heart medications

   Yes___ No___

6. Blood pressure medication

   Yes___ No___

7. Thyroid medications

   Yes___ No___

8. Diuretics/water pills

   Yes___ No___

9. Hormones

   Yes___ No___

		Date First Taken	Date Last Taken
10.	Psychiatric medications Yes___ No___		
11.	Asthma/breathing medications Yes___ No___		
12.	Nasal sprays Yes___ No___		
13.	Attention deficit medications Yes___ No___		
14.	Cocaine/crack cocaine Yes___ No___		
15.	Heroin or methadone Yes___ No___		
16.	Marijuana or hashish Yes___ No___		
17.	LSD, Ecstasy, ICE, PCP, MDMA Yes___ No___		
18.	Amphetamines Yes___ No___		
19.	Inhaled nonprescription substances (e.g., inhalation of glue or toluene) Yes___ No___		
20.	Methysergide (Sansert) Yes___ No___		
21.	Ergotamine preparations (e.g. Cafergot) Yes___ No___		

		Date First Taken	Date Last Taken
22.	L-tryptophan Yes___ No___		
23.	Any medication for migraine headaches Yes___ No___		
24.	Caffeine-containing stimulants (e.g. No-Doz, Vivarin) Yes ___ No ___		
25.	Over-the-Counter appetite suppressants Yes___ No___		
26.	Prescription diet medications Yes___ No___		
27.	Any other prescription medicines regularly taken in the last **10** years Yes___ No___		
28.	Dietary Supplements, vitamins Yes___ No___		
29.	Herbal Products Yes___ No___		
30.	Steroids Yes___ No___		

E. Smoking history (check wherever appropriate)

1. Have you ever smoked cigarettes? Yes___ No___

   If no, skip to E.4.

2. Do you currently smoke cigarettes? Yes___ No___

If yes, state amount smoked: _____ packs per day for _____ years

If no, state date on which smoking ceased _____ and state amount smoked: _____ packs per day for _____ years

3. At the time that you sustained the injuries alleged in the Complaint, were you a smoker of cigarettes? Yes___ No___

If yes, state amount smoked: _____ packs per day for _____ years

4. Have you ever smoked cigars or pipe tobacco? Yes___ No___

If no, skip to F.

5. Do you currently smoke cigars or pipe tobacco? Yes___ No___

If yes, state amount smoked: ___ cigars/pipes per day for ____ years

If no, state date on which smoking ceased _____ and state amount smoked: _____ cigars/pipes per day for _____ years

6. At the time that you sustained the injuries alleged in the Complaint, were you a smoker of cigars or pipe tobacco? Yes___ No___

If yes, state amount smoked: _____ packs per day for _____ years

F. Drinking History

1. Do you currently drink alcohol (beer, wine, whiskey, etc.)?
Yes No
If yes, check which represents your current alcohol consumption.
_____ 1-5 drinks per week
_____6-10 drinks per week
_____ 11-14 drinks per week
_____ 15 or more drinks per week
_____ Other (Describe -_____)

2. Have you ever drunk alcohol (beer, wine, whiskey, etc.)?
Yes_____ No_____
If yes, please check which represents your greatest alcohol consumption over an extended (six (6) months or greater) period within the last 10 Years?
_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 11-14 drinks per week
_____ 15 or more drinks per week
_____Other (Describe-_____)

When was this period? __/__/__ -- __/__/__

3. Check which represents your weekly alcohol consumption for the month prior to the time that you sustained the injuries alleged in the Complaint?

_____ 0 drinks per week
_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 11-14 drinks per week
_____ 15 or more drinks per week
_____ Other (Describe-_____)

G. Caffeine history

1. Do you currently drink caffeinated beverages (coffee, tea, sodas, etc.)?

Yes_____ No_____

If yes, check which represents your current caffeine consumption

_____ 1-3 drinks per day
_____ 3-5 drinks per day
_____ 6 or more drinks per day

2. Have you ever drunk caffeinated beverages (coffee, tea, sodas, etc.)?

Yes_____ No_____

If yes, check which represents your greatest caffeine consumption over an extended period.

_____ 1-3 drinks per day
_____ 3-5 drinks per day
_____ 6 or more drinks per day

When was this period? __/__/__ -- __/__/__

3. Check which represents your daily caffeine consumption for the month prior to the time that you sustained the injuries alleged in the Complaint?

_____ 0 drinks per day
_____ 1-3 drinks per day
_____ 3-5 drinks per day
_____ 6 or more drinks per day

H. Have you ever experienced or been diagnosed or treated for any of the following:

1. Hypertension or high blood pressure Yes___ No___
2. Aneurysm Yes___ No___
3. Obesity Yes___ No___

4.	Eating disorders (e.g. anorexia, bulimia)	Yes___	No___
5.	Arteriovenous malformation ("AVM")	Yes___	No___
6.	Abnormality of blood vessels or circulatory system	Yes___	No___
7.	Blood clots or thrombosis	Yes___	No___
8.	Blood disorders or dyscrasias (abnormal blood cells)	Yes___	No___
9.	Autoimmune disease or condition	Yes___	No___
10.	Rheumatological condition	Yes___	No___
11.	Coagulopathy	Yes___	No___
12.	Any clotting disorder	Yes___	No___
13.	Hepatic (liver) disease or dysfunction	Yes___	No___
14.	Kidney disease	Yes___	No___
15.	Prostate enlargement	Yes___	No___
16.	Stroke of any type (e.g., hemorrhagic stroke, ischemic stroke, intracranial hemorrhage, intracerebral hemorrhage, subarachnoid hemorrhage)	Yes___	No___
17.	Transient ischemic attack	Yes___	No___
18.	Cardiovascular disease or condition	Yes___	No___
19.	Heart or heart valve disease	Yes___	No___
20.	Heart attack	Yes___	No___
21.	Brain tumors	Yes___	No___
22.	Seizure disorder or epilepsy	Yes___	No___
23.	Lupus	Yes___	No___
24.	Diabetes	Yes___	No___
25.	Atherosclerosis	Yes___	No___
26.	Vasculitis	Yes___	No___
27.	Neurological disease or condition	Yes___	No___
28.	High cholesterol	Yes___	No___
29.	High triglycerides	Yes___	No___
30.	Irregular heart beat, arrythmia, heart palpitations, tachycardia and bradycardia	Yes___	No___
31.	Angina, chest pain	Yes___	No___
32.	Bleeding disorder	Yes___	No___
33.	Fainting, dizziness or lightheadedness	Yes___	No___
34.	Head pounding	Yes___	No___
35.	Migraine headaches	Yes___	No___
36.	Memory Loss	Yes___	No___
37.	Arthritis or joint pain	Yes___	No___
38.	Shortness of breath	Yes___	No___
39.	Alcoholism	Yes___	No___

I. If you responded yes to any of the above, please identify the condition, the date of onset and state the name of the physician or other person (and, if not provided in the accompanying list, the address of the physician or the other person) who made the diagnosis or informed you of the condition.

1. Condition:_____

Onset:_____

Name and address of diagnosing physician or other person:

_____

Generic name, brand name, strength and daily dose of any medication prescribed:_____

_____

_____

2. Condition:_____

Onset:_____

Name and address of diagnosing physician or other person:

_____

Generic name, brand name, strength and daily dose of any medication prescribed:_____

_____

_____

3. Condition:_____

Onset:_____

Name and address of diagnosing physician or other person:

_____

Generic name, brand name, strength and daily dose of any medication prescribed:_____

_____

_____

4. Condition:_____

Onset:_____

Name and address of diagnosing physician or other person:

_____

Generic name, brand name, strength and daily dose of any medication prescribed:_____

_____

_____

J. To the best of your knowledge, have your parents, siblings or grandparents or children experienced, been diagnosed with or treated for any of the following:

1. Hypertension or high blood pressure Yes___ No___ Unknown___
2. Aneurysm Yes___ No___ Unknown___
3. Obesity Yes___ No___ Unknown___
4. Eating disorders (e.g., anorexia, bulimia) Yes___ No___ Unknown___
5. Arteriovenous malformation ("AVM") Yes___ No___ Unknown___
6. Abnormality of blood vessels or circulatory system Yes___ No___ Unknown___
7. Blood clots or thrombosis Yes___ No___ Unknown___
8. Blood disorders or dyscrasias (abnormal blood cells) Yes___ No___ Unknown___
9. Autoimmune disease or condition Yes___ No___ Unknown___
10. Rheumatological condition Yes___ No___ Unknown___
11. Coagulopathy Yes___ No___ Unknown___
12. Any clotting disorder Yes___ No___ Unknown___
13. Hepatic (liver) disease or dysfunction Yes___ No___ Unknown___
14. Kidney disease Yes___ No___ Unknown___
15. Prostate enlargement Yes___ No___ Unknown___
16. Stroke of any type (e.g., hemorrhagic stroke, ischemic stroke, intracranial hemorrhage, intracerebral hemorrhage, subarachnoid hemorrhage) Yes___ No___ Unknown___
17. Transient ischemic attack Yes___ No___ Unknown___
18. Cardiovascular disease or condition Yes___ No___ Unknown___
19. Heart or heart valve disease Yes___ No___ Unknown___
20. Heart attack Yes___ No___ Unknown___
21. Brain tumors Yes___ No___ Unknown___
22. Seizure disorder or epilepsy Yes___ No___ Unknown___
23. Lupus Yes___ No___ Unknown___
24. Diabetes Yes___ No___ Unknown___
25. Atherosclerosis Yes___ No___ Unknown___
26. Vasculitis Yes___ No___ Unknown___
27. Neurological disease or condition Yes___ No___ Unknown___
28. High cholesterol Yes___ No___ Unknown___
29. High triglycerides Yes___ No___ Unknown___
30. Irregular heart beat, arrythmia, for heart, palpitations, tachycardia and bradycardia Yes___ No___ Unknown___
31. Angina, chest pain Yes___ No___ Unknown___
32. Bleeding disorder Yes___ No___ Unknown___
33. Fainting, dizziness or lightheadedness Yes___ No___ Unknown___
34. Head pounding Yes___ No___ Unknown___
35. Migraine headaches Yes___ No___ Unknown___
36. Memory Loss Yes___ No___ Unknown___
37. Arthritis or joint pain Yes___ No___ Unknown___
38. Shortness of Breath Yes___ No___ Unknown___
39. Injury to any part of the body Yes___ No___ Unknown___
40. Alcoholism Yes___ No___ Unknown___

K. If you answered yes to any of the preceding, please identify the person who experienced, was diagnosed with or was treated for that condition:

1. Person _____

Relationship _____

Condition _____

Date of onset _____

Name of any medication prescribed: _____

_____

2. Person _____

Relationship _____

Condition _____

Date of onset _____

Name of any medication prescribed: _____

_____

3. Person _____

Relationship _____

Condition _____

Date of onset _____

Name of any medication prescribed: _____

_____

_____

4. Person _____

Relationship _____

Condition _____

Date of onset _____

Name of any medication prescribed: _____

_____

_____

L. If you claim psychological, cognitive or emotional injury as a consequence of using any PPA-containing medications, state whether you have experienced or been treated for any psychological, psychiatric (including depression) or emotional problem prior to the use of the PPA-containing medications at issue.

Yes___ No___

If yes, please state:

1. Name and address of each person who treated you:

a. _____
Name

_____
Street Address (if not otherwise provided)

b. _____
Name

_____
Street Address (if not otherwise provided)

c. _____
Name

_____
Street Address (if not otherwise provided)

2. Condition for which treated

_____

3. When treated

_____

M. Please indicate whether you have received any of the following procedures or surgeries:

1. Heart, lung or other chest surgery Yes___ No___

For what condition?_____

When? _____

Treating physician:

_____

2. Treatment for heart attack or angina Yes___ No___

For what condition?_____

When?_____

Treating physician:

_____

3. Pacemaker Yes___ No___

For what condition?_____

When?_____

Treating physician:

_____

4. By-pass surgery Yes___ No___

For what condition?_____

When?_____

Treating physician:

_____

5. Cranial (brain) surgery Yes___ No___

For what condition?_____

When?_____

Treating physician:

_____

6. Vascular surgery Yes___ No___

For what condition?_____

When?_____

Treating physician:

_____

7. Any other surgery Yes___ No___

For what condition?_____

When?_____

Treating physician:

_____

N. Have you ever received any traumatic injury to your head, neck or chest? Yes___ No___

If yes, please state when and describe the injury.

_____ _____
When Injury

Name of doctor or hospital providing treatment:_____

_____

Medications taken:_____

O. To the best of your knowledge, state whether any of the following tests were administered BEFORE your use of the PPA-containing medications at issue in this lawsuit.

1. Echocardiogram Yes___ No___
2. Electrocardiogram Yes___ No___
3. Electroencephalogram Yes___ No___
4. Arterial or cranial angiogram Yes___ No___
5. MRI, cat-scan or x-ray of the head, neck or brain Yes___ No___
6. MRA (magnetic resonance angiography) Yes___ No___
7. Other diagnostic test or imaging of the brain Yes___ No___

P. For each test for which you answered yes, please identify the treating physician and approximate date of the test.

Test	Treating Physician	Approximate date
Test	Treating Physician	Approximate date

Test	Treating Physician	Approximate date

Q. To the best of your knowledge, state which of the following tests was administered AFTER your use of the PPA-containing medications at issue in this lawsuit.

1.	Echocardiogram	Yes___ No___
2.	Electrocardiogram	Yes___ No___
3.	Electroencephalogram	Yes___ No___
4.	Arterial or cranial angiogram	Yes___ No___
5.	MRI, cat-scan or x-ray of the head, neck or brain	Yes___ No___
6.	MRA (magnetic resonance angiography)	Yes___ No___
7.	Other diagnostic test or imaging of the brain	Yes___ No___

R. For each test for which you answered yes, please identify the treating physician and approximate date of the test.

Test	Treating Physician	Approximate date
Test	Treating Physician	Approximate date
Test	Treating Physician	Approximate date

VII. USE OF COUGH AND COLD MEDICATIONS

Please complete the following chart with respect to each cough and cold medication and product you have taken during the 10 years before your alleged PPA injury through the present.

A. Prescription Medications or Products

Generic Name	Brand Name	Physical Description Including Shape and Color (For Example- round blue tablets)	Description of Packaging	Single Dosage Taken	24 Hour Dosage Taken	First & Last Dates of Use	Prescribed By	Location Where Purchased/ Obtained	Condition Or Symptoms Being Treated

B. Over-The-Counter Products Or Medications

Specific Name Of Product	Manufacturer, If Known	Physical Description Including Shape and Color (For Example- round blue tablets)	Description of Packaging	Single Dosage Taken	24 Hour Dosage Taken	First and Last Dates of Use	Taken On Whose Advice Or Suggestion	Location Where Purchased Or Obtained	Condition Or Symptoms Being Treated

VIII. USE OF WEIGHT LOSS, DIET OR APPETITE SUPPRESSANT PRODUCTS OR MEDICATIONS

If you have used weight loss, diet or appetite suppressant products or medications during the 10 years before your alleged PPA injury through the present, please complete the following chart with respect to each such medication or product you have taken within that time.

A. Prescription Medications

Specific Name Of Product	Manufacturer, If Known	Physical Description Including Shape and Color (For Example- round blue tablets)	Description of Packaging	Single Dosage Taken	24 Hour Dosage Taken	First and Last Dates of Use	Taken On Whose Advice Or Suggestion	Location Where Purchased Or Obtained	Condition Or Symptoms Being Treated

B. Over-The-Counter Products Or Medications

Specific Name Of Product	Manufacturer, If Known	Physical Description Including Shape and Color (For Example- round blue tablets)	Description of Packaging	Single Dosage Taken	24 Hour Dosage Taken	First and Last Dates of Use	Taken On Whose Advice Or Suggestion	Location Where Purchased Or Obtained	Condition Or Symptoms Being Treated

IX. THE INJURY

A. On what date and time did you first experience any symptoms you believe are related to the injury alleged in your Complaint?

_____

B. In what city and state were you when you experienced those symptoms?

_____

C. Were there any witnesses to the symptoms identified above? If so, state their names, addresses, phone numbers and relationship to you.

_____

_____

_____

D. When did you first contact a doctor or healthcare professional concerning this injury?

_____

_____

_____

E. Who was the first such contact?

_____

_____

_____

F. If you were taken to a doctor or health care facility for the injury alleged in the complaint, state the name and address of the persons, police department, fire department, emergency medical workers, or ambulance company who took you to the doctor or health care facility.

_____

_____

_____

G. When did you obtain the PPA-containing medication which you claim caused your injuries?

_____

_____

_____

H. State the name and address of the retailer from whom the PPA-containing medication which you claim caused your injuries was obtained?

_____

_____

_____

I. Was there any expiration date on that medicine? If so, what?_____

J. Describe how the medicine was packaged, including the size and color of the packaging and/or box._____

K. If that packaging contained a "seal," was the seal broken when you obtained the medicine?_____

L. Who has possession of the packaging, inserts and labeling of all PPA-containing products which you claim caused your injuries?_____

M. State any lot number or other identification numbers on the medicine or its packaging._____

_____

N. State the form of the medicine (liquid, pill, capsule)._____

_____

O. For each medication (prescription or over the counter), drug (licit or illicit), chemical, dietary supplement, appetite suppressant or herbal remedy you recall taking at any time during the thirty (30) days preceding your injury, complete the following table.

Name of Substance	Trade Name, If Any	Date and Time Taken	Amount Taken	Prescribed by or on Whose Advice	Reason for Taking It

P. For each caffeine-containing substance you recall taking during the 72 hours preceding the incident (including coffee, tea, colas, etc.), complete the following table.

Name of Substance	Trade Name, If Any	Date and Time Taken	Amount Taken	Amount Consumed Within 6 Hours of the Incident

Q. Have you had discussions with any physician(s) about whether your condition is related to the use of PPA-containing medications?

Yes_____ No_____

If yes, please identify:

Name of doctor:_____

Address:_____

Specialty:_____

Date of discussion:_____

and, check one of the following:

1. I was told my condition is related to the use of PPA-containing medications. _____

2. I was told my condition is not related to the use of PPA-containing medications. _____

3. I was told my condition may be related to the use of PPA-containing medications. _____

4. I was told by the doctor that he does not know whether my condition is related to the use of PPA-containing medications. _____

5. I don't recall what I was told. _____

If discussed with more than one doctor, please copy and complete Part A for each.

X. DAMAGE CLAIMS

A. If you claim or expect to claim that you lost earnings or suffered impairment of earnings capacity as a result of any condition which you believe was caused by your PPA-containing medication:

1. Complete the following information with respect to your employment for ten years prior to your alleged PPA injury to the present.

Employers	Address	Type of Business/Position	Dates of Employment	Salary	Overtime	Bonus

2. State the total amount of time which you have lost from work as a result of any condition which you claim or believe was caused by your use of PPA-containing medications and the amount of income which you lost.

_____

_____

_____

B. Have you paid or incurred any medical expenses, including amounts billed or paid by insurers and other third party payors, which are related to any condition which you claim or believe was caused by your use of PPA-containing medications for which you seek recovery in the action which you have filed?

Yes_____ No_____

If yes, please state the total amount of such expenses at this time. $_____

C. Please identify all persons who you believe possess information concerning your injury and/or your current medical conditions and for each, state their name, address, telephone number and a description of the information you believe they possess.

_____

_____

_____

_____

_____

_____

XI. DOCUMENTS

Please attach the following documents to this declaration, to the extent that such documents are currently in your possession or in the possession of your lawyers.

A. TEN ORIGINAL SIGNED authorizations for the release of records in the form appended hereto.

B. A copy of all medical records from any physician, diet center, hospital or health care provider, who treated you for any disease, condition or symptom referred to in any or your responses to the questions above.

C. A copy of all medical records from any physician, diet center, hospital or health care provider, who treated you at any time for any neurological or cardiovascular disease, condition or symptom referred to in your response to the questions above.

D. To the extent not included in the foregoing, all records relating to any examination by a physician or other health care provider, conducted for any purpose, other than psychiatric or psychological evaluation, in the period beginning five (5) years prior to the date upon which you used the PPA-containing medications you claim caused your injury to date.

E. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.

F. All diagnostic tests or test results including reports of echocardiograms, angiograms, cat-scans, MRIs, MRAs or electroencephalograms taken within the last ten (10) years.

G. All diagnostic tests or test results including reports of echocardiograms, angiograms, cat-scans, MRIs, MRAs or electroencephalograms relating to any neurological or cardiovascular condition done at any time.

H. Copies of all documents from physicians, healthcare providers or others relating to the use of PPA-containing medications, or to any condition you claim is related to the use of PPA-containing medications.

I. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, height and weight charts, pharmacy handouts or other materials distributed with or provided to you in connection with your use of PPA-containing medications.

J. Copies of advertisements or promotions for PPA-containing medications.

K. The entire packaging, including the bottle, box and label for the PPA-containing medication you allege caused you injury and any remaining medication.

L. All documents relating to your purchase of PPA-containing medications, including, but not limited to, receipts, prescriptions or records of purchase.

M. All documents relating to PPA or any alleged health risks or hazards related to PPA in your possession at or before the time of the injury alleged in your Complaint.

N. All documents you (and not your lawyer) obtained directly or indirectly from any defendant.

O. All photographs, drawings, journals, slides or videos relating to your alleged injury after the incident, including "day-in-the-life" videotapes.

P. Copies of all documents you (and not your attorneys) obtained from any source related to PPA or to the alleged effects of ingesting PPA-containing products or medications.

Q. If you claim you have suffered a loss of earnings or earning capacity, your federal tax returns for each of the years from ten (10) years prior to your injury to the present.

R. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider.

S. Copies of letters testamentary or letters of administration relating to your status as plaintiff.

T. Decedent's death certificate (if applicable).

DECLARATION

I declare under penalty of perjury that all of the information provided in this Plaintiff's Fact Sheet is true and correct to the best of my knowledge, information and belief, that I have completed the List of Medical Providers and Other Sources of Information appended hereto, which is true and correct to the best of my knowledge, information and belief, that I have supplied all the documents requested in Part XI of this declaration, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the authorizations attached to this declaration.

_____ _____

Signature Date

IN RE: PHENYLPROPANOLAMINE ("PPA") PRODUCTS LIABILITY LITIGATION
UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE
MDL NO. 1407

LIST OF MEDICAL PROVIDERS
AND OTHER SOURCES OF INFORMATION

EACH PLAINTIFF WHO IS REQUIRED TO COMPLETE A DECLARATION MUST FULLY AND ACCURATELY COMPLETE THIS FORM LISTING MEDICAL CARE PROVIDERS AND OTHER SOURCES OF INFORMATION AS REQUESTED.

List the name and address of each of the following:

A. Your current primary care physician(s):

_____
Name

_____
Street Address

_____
City, State, Zip Code

B. To the best of your ability, identify each of your primary care physicians for the 10 years prior to your PPA injury through the present:

1. _____ _____
Name Approximate dates

_____
Last known address

_____
City, State, Zip Code

2. _____ _____
Name Approximate dates

_____
Last known address

_____
City, State, Zip Code

3. _____ _____
Name Approximate dates

_____
Last known address

_____
City, State, Zip Code

4. _____ _____
Name Approximate dates

_____
Last known address

_____
City, State, Zip Code

C. Each cardiologist or neurologist who has ever seen or treated you:

1. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

2. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

3. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

4. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

D. Each nutritionist/dietician or other weight loss counselor who has ever seen or treated you.

1. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

2. _____

Name

_____

Specialty

_____

Street Address

_____

City, State, Zip Code

3. _____

Name

_____

Specialty

_____

Street Address

_____

City, State, Zip Code

4. _____

Name

_____

Specialty

_____

Street Address

_____

City, State, Zip Code

E. Each hospital where you have received inpatient treatment during the 10 years prior to your PPA injury through the present:

1. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

2. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

3. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

4. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

F. Each hospital or healthcare facility where you have received outpatient treatment (including treatment in an emergency room) during the 10 years prior to your PPA injury through the present:

1. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

2. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

3. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

4. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

5. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

G. Each other physician or healthcare provider from whom you have received treatment, with whom you have consulted regarding your health, or who has examined you in the 10 years prior to your PPA injury through the present, *with the exception of psychiatrists or psychologists:*

1. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

2. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

3. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

4. _____

Name

_____

Specialty

_____

Street Address

_____

City, State, Zip Code

5. _____

Name

_____

Specialty

_____

Street Address

_____

City, State, Zip Code

6. _____

Name

_____

Specialty

_____

Street Address

_____

City, State, Zip Code

7. _____

Name

_____

Specialty

_____

Street Address

_____

City, State, Zip Code

8. _____

Name

_____

Specialty

_____

Street Address

_____

City, State, Zip Code

9. _____

Name

_____

Specialty

_____

Street Address

_____

City, State, Zip Code

10. _____

Name

_____

Specialty

_____

Street Address

_____

City, State, Zip Code

H. Each pharmacy, drugstore and the like where you have had prescriptions filled during the 10 years prior to your PPA injury through the present:

1. _____
Name

_____
Street Address

_____
City, State, Zip Code

2. _____
Name

_____
Street Address

_____
City, State, Zip Code

3. _____
Name

_____
Street Address

_____
City, State, Zip Code

4. _____
Name

_____
Street Address

_____
City, State, Zip Code

5. _____

Name

_____

Street Address

_____

City, State, Zip Code

I. If, *but only if*, you claim that you suffered psychological or emotional injuries as a result of using PPA-containing medications, list each psychiatrist, psychologist, mental health counselor, therapist and/or social worker from whom you have received treatment or with whom you have consulted regarding your health during the 10 years prior to your PPA injury through the present:

1. _____

Name

_____

Street Address

_____

City, State, Zip Code

2. _____

Name

_____

Street Address

_____

City, State, Zip Code

3. _____

Name

_____

Street Address

_____

City, State, Zip Code

J. If you have submitted a claim for social security disability benefits in the 10 years prior to your PPA injury through the present, state the name and address of the office which is most likely to have records concerning your claim.

_____

Name

_____

Street Address

_____

City, State, Zip Code

K. If you have submitted a claim for workers compensation in the 10 years prior to your PPA injury through the present, state the name and address of the office which is most likely to have records concerning your claim.

_____

Name

_____

Street Address

_____

City, State, Zip Code

[ATTACH ADDITIONAL SHEETS, IF NECESSARY TO COMPLETE EACH SUBSECTION]

IN RE: PHENYLPROPANOLAMINE ("PPA") PRODUCTS LIABILITY LITIGATION
UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE
MDL NO. 1407

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of all medical records, including, but not limited to, medical reports, radiographic films, CT scans, X-rays, MRI films, MRA films, correspondence, progress notes, prescription records, echocardiographic recordings, written statements, employment records, wage records, disability records, medical bills, and other documents in your possession concerning _____

Name of Patient

whose date of birth is _____ and whose social security number is _____

_____.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

_____
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

_____
Street Address

City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization is not valid unless the record requestor named above has executed the acknowledgment at the bottom of this authorization.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Date:_____ _____

Patient or Guardian Signature

Date:_____ _____

Witness Signature

AUTHORIZATION

The undersigned, as the record requestor named in the above medical authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the patient named in the foregoing medical authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed, if named in Plaintiff's List of Medical Providers; or, if the authorization is addressed to a third party not listed in Plaintiff's List of Medical Providers, the attorney for the patient named has been given ten (10) days advance notice and has been afforded an opportunity to object to the request, and any objections have been resolved. The attorney for the patient named in the foregoing medical authorization has also been afforded an opportunity to order copies of the records requested from the undersigned requestor at a reasonable cost.

_____

[NOTE: COMPLETE THIS FORM ONLY IF YOU ARE MAKING A CLAIM FOR LOST EARNING OR LOST EARNING CAPACITY]

IN RE: PHENYLPROPANOLAMINE ("PPA") PRODUCTS LIABILITY LITIGATION
UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE
MDL NO. 1407

AUTHORIZATION FOR RELEASE OF EMPLOYMENT
AND UNEMPLOYMENT INFORMATION AND RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of all applications for employment, resumes, records of all positions held, job descriptions of positions held, salary and/or compensation records, performance evaluations and reports, statements and comments of fellow employees, attendance records, W-2's, workers' compensation files; all hospital, physician, clinic, infirmary, nurse, psychiatric and dental records; x-rays, test results, physical examination records; any records pertaining to claims made relating to health, disability or accidents in which I was involved including correspondence, reports, claim forms, questionnaires, records of payments made to me or on my behalf; and any other records relating to my employment with the above-named institution concerning _____

Name of Employee

whose date of birth is _____ and whose social security number is _____

_____

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records.

_____ _____

Name of Representative

_____

Representative Capacity (e.g. attorney, records requestor, agent, etc.)

_____

Street Address

_____

City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization is not valid unless the record requestor named above has executed the acknowledgment at the bottom of this authorization.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Date:_____ _____

Employee or Guardian Signature

Date:_____ _____

Witness Signature

AUTHORIZATION

The undersigned, as the record requestor named in the above authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the employee named in the foregoing authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed, the attorney for the employee named has been given ten (10) days advance notice and has been afforded an opportunity to object to the request, and any objections have been resolved. The attorney for the employee named in the foregoing authorization has also been afforded an opportunity to order copies of the records requested from the undersigned requestor at a reasonable cost.

_____

[NOTE: COMPLETE THIS FORM ONLY IF YOU HAVE MADE A WORKERS' COMPENSATION OR SOCIAL SECURITY DISABILITY CLAIM DURING THE 10 YEARS PRIOR TO YOUR PPA INJURY THROUGH THE PRESENT]

IN RE: PHENYLPROPANOLAMINE ("PPA") PRODUCTS LIABILITY LITIGATION
UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE
MDL NO. 1407

AUTHORIZATION FOR RELEASE OF
WORKERS' COMPENSATION AND SOCIAL SECURITY RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all workers' compensation and social security records of any sort, including but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts, or other documents, concerning _____

_____

Name of Claimant

whose date of birth is _____ and whose social security number is _____

_____

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records.

Name of Representative

Representative Capacity (e.g. attorney, records requestor, agent, etc.)

Street Address

City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization is not valid unless the record requestor named above has executed the acknowledgment at the bottom of this authorization.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Date:_____

Claimant or Guardian Signature

Date:_____

Witness Signature

AUTHORIZATION

The undersigned, as the record requestor named in the above authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the claimant named in the foregoing medical authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed, the attorney for the patient named has been given ten (10) days advance notice and has been afforded an opportunity to object to the request, and any objections have been resolved. The attorney for the claimant named in the foregoing authorization has also been afforded an opportunity to order copies of the records requested from the undersigned requestor at a reasonable cost.

_____

[NOTE: COMPLETE THIS FORM ONLY IF YOU ARE MAKING A CLAIM FOR LOST EARNING OR LOST EARNING CAPACITY]

IN RE: PHENYLPROPANOLAMINE ("PPA") PRODUCTS LIABILITY LITIGATION
UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE
MDL NO. 1407

AUTHORIZATION FOR RELEASE OF FINANCIAL/TAX RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of all any and all financial/tax records of any sort, including but not limited to, statements, applications, disclosures, correspondence, notes, agreements, contracts, or other documents, concerning _____.
Name of Taxpayer

whose date of birth is _____ and whose Social Security number is _____.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

_____
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

_____
Street Address

City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization is not valid unless the record requestor named above has executed the acknowledgment at the bottom of this authorization.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Date: _____

Taxpayer or Guardian Signature

Date:_____ _____

Witness Signature

AUTHORIZATION

The undersigned, as the record requestor named in the above authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the taxpayer named in the foregoing authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed, the attorney for the patient named has been given ten (10) days advance notice and has been afforded an opportunity to object to the request, and any objections have been resolved. The attorney for the taxpayer named in the foregoing authorization has also been afforded an opportunity to order copies of the records requested from the undersigned requestor at a reasonable cost.

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